Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Castle Hills, ASC

Respondent Name
Chubb Indemnity Co

MFDR Tracking Number
M4-14-1607-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
February 3, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is of our opinion that we are still owed $13,372.32 by Chubb Group of Insurance, due to being paid based on incorrect rates. Our initial billed charges were $14,100.00 and we did receive payment in the amount of $4,239.65; however, rates should have been calculated for facility claim per Medicare's 235% rate."

Amount in Dispute: $13,372.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Requestor now states that they are owed $235% of the Medicare rate, however, because they requested separate reimbursement for the implant, they were only owed 153% of the Medicare rate, which was paid. No further reimbursement is due.

Response Submitted By: Downs Stanford PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 19, 2013	27446	$13,372.32	$7,230.49

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402 sets out the guidelines for reimbursement for services provided in ambulatory surgical centers.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment

Issues

1. Did the requestor request support calculation of fees?
2. What is the applicable rule in determining appropriate fee(s)?
3. Is the requestor entitled to reimbursement?

Findings

1. The respondent stated in their position statement, "…they requested separate reimbursement for the implant" Review of the medical bill dated 09/19/2013 finds a statement in box 19, "Separate Reimbursement to Access Mediquip for Implant." The respondent's position is supported.

2. Per 28 Texas Administrative Code §134.402(f) states in pertinent part, "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR (date of service), or its successor. The following minimal modifications apply: …(B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and (ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent." Review of the submitted documentation finds:

3. The maximum allowable reimbursement (MAR) will be calculated as follows;

Date of Service	Submitted Code	Amount Billed	Rule 134.402 (f) MAR (Geographically adjusted Medicare ASC reimbursement)
September 19, 2013	27446	$14,100.00	ASC reimbursement divided by 2, multiplied by CBSA city wage index, sum of these two, multiplied by 153% or $7,888.90 ÷2= $3,944.45 x 0.9006 = $3,552.37 $3,994.45 + $3,552.37 = $7,496.82 x 153% = $11,470.13
	TOTAL	$14,100.00	$11,470.13

4. The total maximum allowable reimbursement for the services in dispute if $11,470.13. The carrier previously paid $4,239.64. The remaining balance is $7,230.49. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $7,230.49.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $7,230.49 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.